McLaren
HEALTH PLAN COMMUNITY

Plan Year		2019	
Plan Name		McLaren Bronze 6500 Plan	
Market		Small Group	
Category	**Service**	**In Network**	**Out of Network**
General Plan Information	Individual Deductible	$6,500	Not Applicable
	Family Deductible	$13,000	Not Applicable
	Member's Coinsurance	50%	Not Applicable
	Individual OOP Max	$7,900	Not Applicable
	Family OOP Max	$15,800	Not Applicable
Preventive Care	Preventive Care/Screening/Immunization	No Charge	Not Covered
	Well Baby Visits and Care	No Charge	Not Covered
Office Visits	Primary Care Visit to Treat an Injury or Illness	50% Coinsurance after deductible	Not Covered
	Specialist Visit	50% Coinsurance after deductible	Not Covered
	Mental/Behavioral Health Outpatient Services	50% Coinsurance after deductible	Not Covered
	Substance Abuse Disorder Outpatient Services	50% Coinsurance after deductible	Not Covered
	Other Practitioner Office Visit	50% Coinsurance after deductible	Not Covered
Emergency Care	Urgent Care Centers or Facilities	50% Coinsurance after deductible	50% Coinsurance after deductible*
	Emergency Room Services	50% Coinsurance after deductible	50% Coinsurance after deductible*
	Emergency Transportation/Ambulance	50% Coinsurance after deductible	50% Coinsurance after deductible*
Laboratory and Imaging	Laboratory Outpatient and Professional Services	50% Coinsurance after deductible	Not Covered
	X-rays and Diagnostic Imaging	50% Coinsurance after deductible	Not Covered
	Imaging (CT/PET Scans, MRIs)	50% Coinsurance after deductible	Not Covered
Maternity Care	Prenatal Office Visits	No Charge	Not Covered
	All Other Maternity Care	50% Coinsurance after deductible	Not Covered
Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	50% Coinsurance after deductible	Not Covered
	Outpatient Surgery Physician/Surgical Services	50% Coinsurance after deductible	Not Covered
Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	50% Coinsurance after deductible	Not Covered
	Inpatient Physician and Surgical Services	50% Coinsurance after deductible	Not Covered
	Mental/Behavioral Health Inpatient Services	50% Coinsurance after deductible	Not Covered
	Substance Abuse Disorder Inpatient Services	50% Coinsurance after deductible	Not Covered
Surgery	Reconstructive Surgery	50% Coinsurance after deductible	Not Covered
	Bariatric Surgery	50% Coinsurance after deductible	Not Covered
	Transplant	50% Coinsurance after deductible	Not Covered
	Treatment for Temporomandibular Joint Disorders	50% Coinsurance after deductible	Not Covered
	Accidental Dental	50% Coinsurance after deductible	Not Covered

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Home Health Care	**Home Health Care Services**	50% Coinsurance after deductible	Not Covered
	Hospice Services	50% Coinsurance after deductible	Not Covered
	Habilitation Services	50% Coinsurance after deductible	Not Covered
	Skilled Nursing Facility	50% Coinsurance after deductible	Not Covered
Autism Treatment	**Outpatient Mental Health Services to Treat Autism**	50% Coinsurance after deductible	Not Covered
	Habilitation Services to Treat Autism	50% Coinsurance after deductible	Not Covered
Other Services	**Chiropractic Care**	50% Coinsurance after deductible	Not Covered
	Diabetes Education	50% Coinsurance after deductible	Not Covered
	Allergy Testing	50% Coinsurance after deductible	Not Covered
	Routine Eye Exam (Adult)	50% Coinsurance after deductible	Not Covered
	Routine Eye Exam for Children	50% Coinsurance after deductible	Not Covered
	Eye Glasses for Children	50% Coinsurance after deductible	Not Covered
	Infertility Treatment	50% Coinsurance after deductible	Not Covered
	Weight Loss Programs	50% Coinsurance after deductible	Not Covered
	Chemotherapy	50% Coinsurance after deductible	Not Covered
	Dialysis	50% Coinsurance after deductible	Not Covered
	Durable Medical Equipment	50% Coinsurance after deductible	Not Covered
	Infusion Therapy	50% Coinsurance after deductible	Not Covered
	Outpatient Rehabilitation Services	50% Coinsurance after deductible	Not Covered
	Prosthetic Devices	50% Coinsurance after deductible	Not Covered
	Radiation	50% Coinsurance after deductible	Not Covered
	Rehabilitative Occupational and Rehabilitative Physical Therapy	50% Coinsurance after deductible	Not Covered
	Rehabilitative Speech Therapy	50% Coinsurance after deductible	Not Covered
	Prescription Drugs Other	50% Coinsurance after deductible	Not Covered
	Mental Health Other	50% Coinsurance after deductible	Not Covered
Prescription Drugs	**Generic Drugs**	$30	Not Covered
	Preferred Brand Drugs	$70	Not Covered
	Non-Preferred Brand Drugs	$200	Not Covered
	Specialty Drugs	$300	Not Covered

* Balance billed amounts charged by the provider are the responsibility of the member

McLaren Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:
ملحوظة:إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671 (رقم هاتف الصم والبكم: 711).